Session 2 – Questions and Answers

Recently I was in a meeting, and we talked about advanced PrEP, one per Month, injection after 3 months and implantation for one Year. Is it on Platform yet?

> *Response*: Currently, WHO has released recommendations for TDF-based oral PrEP and the dapivirine vaginal ring. Oral PrEP can be used as daily PrEP for all populations apart from cisgender MSM. Cisgender MSM have also the option of event-driven PrEP. The dapivirine vaginal ring can be used by cisgender women and involves a ring that is kept in the vagina for 28 days. Some countries are currently reviewing, and some have already approved it (e.g. Zimbabwe). Long-acting injectable cabotegravir is an injection that is given every 8 weeks. It is currently under review by FDA and will be considered by WHO after that. It is not available outside of research settings. Similarly other options (e.g., implants) are not available outside of research yet.

For those without internet and no access to a mobile phone, what options we are given to them in terms of information?

> *Response*: Internet-based or other telehealth interventions are just one option to reach individuals with information and services. Offline services will continue to play an important role in HIV prevention. This includes facility-based services or services and information provided in communities, including provided by peer providers - as just described by Dr Akolo. Comprehensive sexuality education is also an important component of the response to HIV and STIs

How can an organisation implementing KP (PWID) program know some of the technology innovations or how can we lay hands/benefit from the technology innovation for improved implementation of KP programs?

> *Response*: There are a lot of great resources out there. You can find information on the WHO website for PrEP (https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/hiv/prevention/pre-exposure-prophylaxis) and the WHO Global PrEP Network (https://www.who.int/groups/global-prep-network). Another great resource is https://www.prepwatch.org/, where there is also information on new PrEP products. I'm sure others can share more resources.
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> *Response*: Session 10 in this meeting will focus on virtual interventions, and some of the resources have already been posted on the meeting website here.

Ma question est paraport a la prévention du vih aux pops clés et que nous savons que ya d'autres patologíes qui peuvent les affectées et qui sont beaucoup plus virulent que le VIH trouvé vous pas aujourd'hui que les tests et diagnostic Précoce de ses maladies doivent être intégrés dans les premières contacts de la personne face à ses besoins pour éviter toute désagréments da's la prévention comme dans la PEC si cela est possible.

My question is related to the prevention of HIV in key pops and that we know that there are other pathologies which can affect them, and which are much more virulent than the HIV found you not today than the tests and early diagnosis of his diseases must be integrated in the first contacts of the person facing his needs to avoid any inconvenience in the prevention as in the PEC if this is possible.

> *Response*: Person-centred and differentiated care is key, which involves integrating HIV prevention with services for the prevention and treatment of other conditions. There are often very high needs for addressing STIs in particular among key populations. As Dr Akolo mentioned, other needs that should be addressed are mental health and gender-based violence. We should

not consider health needs in isolation. Addressing multiple health needs can create efficiencies in programmes and ensures that everyone's complex health needs are met.

Les soins différenciés et centrés sur la personne sont essentiels, ce qui implique d'intégrer la prévention du VIH aux services de prévention et de traitement d'autres affections. Les besoins en matière de lutte contre les IST, en particulier parmi les populations clés, sont souvent très importants. Comme l'a mentionné le Dr Akolo, d'autres besoins auxquels il convient de répondre sont la santé mentale et la violence sexiste. Nous ne devons pas considérer les besoins de santé isolément. Répondre à de multiples besoins de santé peut créer des gains d'efficacité dans les programmes et garantir que les besoins de santé complexes de chacun sont satisfaits.

In Kenya, many are waiting for the one-month pill, has it been proven yet?

Response: The one monthly PrEP product Islatravir is not yet approved by any regulatory authority or recommende by WHO. It is being evaluated by research studies, including a large randomised controlled trial, but we don't have the results of this yet (and it will still take a while).

How to include/extend the DSD to other KP groups like vulnerable populations, people living with disabilities, people living in closed settings, adolescents and young women?

Response: Great question - part of the definition of DSD is "meeting the needs and expectations" of recipients of care, so advocating for accessible design and delivery is key. There are two presentations on services for inmates/prisoners at this meeting, FYI. Session 3b and Session 6b.

With the skewness in the global 10-10-10 targets to that 95-95-95 targets - how to reconcile these targets in the prevention and treatment cascade for KP in the context of emerging legal barriers?

Response: It is true that laws and policies often create significant barriers to access to prevention and treatment services for KPs. This is recognized in the global 10-10-10 targets. Addressing these structural barriers in many settings is key to achieving other targets. In the United General Assembly, nearly all countries in the world have committed to these targets, which includes creating an enabling environment and removing these barriers. There is also a evidence that removing legal barriers can have significantly improve access to care. All this is important to point out to policy makers. - But indeed, addressing legal barriers remains an ongoing challenge.

For Chris Akolo, we are interested to understand how the team is doing the community GBV screening and linkage to other services

Response: Thanks for the question. The project engaged and trained peer educators and outreach workers on violence prevention and response. The training also built their capacity to screen all clients for GBV and ensure survivors are linked to appropriate services at their sites or even outside the program. A lot of the peer educators have the capacity to provide immediate support, including psychosocial support to these clients. A lot of them are also paralegals. You can access more information through this link. https://www.fhi360.org/resource/linkages-violence-prevention-and-response-series

Can you comment on frequent PEP users transitioning to PrEP, are you seeing increased uptake from this cohort or is PEP preferred over PrEP?

Response: Individuals who were on PEP but continue to be at ongoing risk (after completing the course of PEP) should be offered PrEP. We are beginning to see a number of individuals in this

category. However, we have not started looking at their preference. What is important is ensuring the needs of each client are met as much possible.

il semble qu'en Ouganda l'hosexualité est l'objet des lois punitives. Comment sont alors organisés les services de prévention en faveur des populations clés?

It seems that in Uganda homosexuality is the object of punitive laws. How are prevention services organized for key populations?

My question is about government led programming, how can this happen when we still have environment and legal hostilities?

Response: Services are offered on multiple fronts based on the public health approach. In 2014, when the anti-homosexuality act was passed (later repealed and in use currently), the MOH provided a directive to all health workers to offer services without stigmatizing or discrimination of any individual. The investment case for Uganda has demonstrated that the country has achieved significant progress in the fight against HIV, but certain population are left behind and these if not attended too, may reverse the gains. The health sector strategic plan outlines critical interventions and population that need to be reached for Uganda to end AIDS as a public health burden. All these have been informed by evidence. So MSM being recognized as a key population to attend to has enable the programmers to convince the policy makers to buy in the implementation of programs to reach these population left behind such as MSM. MSM have also been supported to operate dedicated clinics. Lastly there is a strong advocacy community of MSM that has come up to form a consortium of KPs to advocate for rights to access of health services, etc. These have been able to seek audiences of ministers of health parliamentarians and enforcement agencies to foster buy in Note: also check the Uganda presentation for a slide on engaging different actors

How can you provide DSD for KP at hotspots? Can you share examples, please?

Response: There will be many case studies on this topic during the meeting. Some examples will be in sessions 3a, 3b, 6b, 9b and more.

Thanks, Dr Akolo, for the great work FHI/EPIC is doing. Great to note how capacities of communities are built to participate in HIV response (DSD). However, is your project looking at what next after it. Am particularly interested in community ownership in terms of funding, any thought?

Response: We keep sustainability in mind as we continue to implement these various approaches. EpiC also focuses on supporting the CSOs to diversify their funding sources and we are beginning to see a few governments showing interest in funding some aspect of KP program, especially those related to commodity supply and HTS.

If Sex work and same-sex relationship are criminalized in UG how did you manage to establish MARPI program and scaling KP services to 702 government facilities to provide services to people who are practicing criminalized activities?

Response: The Uganda investment case has demonstrated the interventions with highest impact and guided our response ... including prioritization of KP programs but also informing the policy advocacy... There is also a strong community advocacy which we work with to engage enforcement agencies not to arrest services providers or recipients of care during service delivery sessions

According to HIV/AIDS National Strategic Plan for Ethiopia 2021-2025, Ethiopia has defined Key Populations taking into consideration of local epidemiology, HIV prevalence, high risk behaviors increased morbidity and mortality or higher vulnerabilities hence, FSWs, Prisoners and PWID are KPs in Ethiopia context therefore we are happy to learn/know that any effective DSD model intervention particularly for PWID and Can you briefly describe how it works (the operationalization part).

Response: There will be case studies and examples of DSD for PWID in sessions 3b, 9b and 11d.

I would like to know if the community being served by your project, Dr Akolo, are willing to pay for the services?

Response: As part of our decentralized drug delivery model, we conducted an assessment of the willingness to pay for some services (mostly related to ART though) and a lot of clients were willing to pay. This is becoming more relevant as we start expanding service delivery into the private sector. Therefore, engaging the KP community in the design and rollout of interventions remains important.

Can you please explain what a MARPI clinic is? Please also indicate what services are provided at this clinic.

Response: MARPI stands for "most at risk population initiative" clinic. It's located in a government facility and currently provides the full range of HIV and health services for KP/PP. It also provides capacity building for CSOs and government to deliver KP friendly health and HIV services

I create awareness about most of the LGBTIQA+ organization in Kenya. And in that way, I get questions from the LGBTIQA community members from Uganda if there is such facility in Uganda. My question is how many facilities are there in Uganda that offers services to our community members?
I have few Ugandans who come to Kenya for the services. What's the intake of that?

Response: I agree there are also some Kenyans who seek services in Tororo and Busia. I was looking at the data in Busia yesterday and I found this crisscrossing occurring.

Thank you, Chris, for your presentations. Few questions: 1. What are the packages of virtual/online model of DSD you used? 2. What criteria are used to categorize KPs as high, medium and low risk and how the positivity rate you got from each categorized risks and which category found with high positivity rate?

Response: Thanks for the questions. You can find answers to these questions and other relevant information through the materials available here: https://www.fhi360.org/resource/going-online-accelerate-impact-hiv-programs

What are the leading interventions led you to get declining GBV among FSWs across the quarters?

Response: The data presented only showed decline in the number of reported cases of GBV and not necessarily GBV in itself. The program is working closely with law enforcement, bar owners, clients at hotspots, as well as ensuring that peer educators and outreach workers are capacitated to provide immediate support to GBV survivors, in addition to linking them to relevant post-GBV services. Most of the KPs have also been oriented on ways to minimize risk of violence, including from clients and partners.

How were you able to engage key stakeholders, the community, security and policy makers to a meeting of this magnitude?

Response: The SHs are part of regular TWG meetings... so engagements are easily achieved

Dans quelles structures les populations clés préfèrent-elles être suivies pour les soins ? est-ce dans les sites intégrés (KP clinics) ou dans les centres conviviaux (DIC) et pourquoi?

In which structures do key populations prefer to be followed for care? is it in the integrated sites (KP clinics) or in the user-friendly centers (DIC) and why?

Response: The DICs and Clinics offer different services and are often located in different places. Sometimes we have co-location of DIC and clinic –these are preferred. But KPs tend to have preference for dedicated individual health workers or peers they can confide in than the clinic or DIC.

What are the other strategies than DIC used in Kenya to put clients on PrEP and how is the retention of those clients started PrEP at facility and community?

Response: The program uses different strategies for creating demand for PrEP services at the outreach venues and at the DICs. All clients who access services at the outreach venues or at the DICs are offered HTS and those who test negative but are at high risk of HIV acquisition or who specifically request PrEP are offered it. Peer educators provide adherence support to PrEP clients and are also able to help address issues related to side effects. There are challenges with overall retention on PrEP and definitely not all those who started PrEP continue at 3 months, 6 months, 9 months or longer. However, the focus of the program is ensuring all clients with ongoing risk continue to access PrEP. Since our PrEP program is mostly at the community level, we are unable to compare retention between both models.

Quid de la stigmatisation et discrimination à l'endroit des populations clés dans les structures des soins (KP clinics) en Ouganda?

Réponse: La stigmatisation continue d'être rampante entre les installations, cependant avec la formation et les fournisseurs de services dédiés, KPS développent des services de confiance et de recherche. Nous avons eu des exemples dans l'une des installations où les agents de santé formés / dévoués ont été déplacés et quelques mois, tous les KPS accessibles aux services de ces installations ont cessé de venir pour des services et passaient à d'autres installations avec des agents de santé dédiés.

Remarque, les fournisseurs de cliniques et de services KP doivent être dédiés à la clinique d'art, et que chaque HW dans l'établissement ne soit pas disposé ou devrait travailler dans l'installation de KP. La formation et les mentorats en cours sont essentiels. Si la clinique est soutenue par le donateur, il est important de tirer parti des ressources nécessaires pour soutenir d'autres services de santé.

What about the stigma and discrimination against key populations in healthcare facilities (KP clinics) in Uganda?

Response: Stigma continues to be rampant across facilities, however with training and dedicated services providers, KPs develop trusted and seek out services. We have had examples in one of the facilities where the trained/dedicated health workers were shifted and within a few months all KPs accessing services at those facilities stopped coming for services and shifted to other facilities with dedicated health workers.

Note, KP clinics and services providers should be dedicated just like for ART clinic, not every HW in the facility is willing or should work in the KP facility. Training and ongoing mentorships are critical. If the clinic is supported by donor, it's important to leverage some resources to support other health services provision

In UGANDA do you use specific books to register each beneficiary's categories who receive health services or only there are specific books to register Key Populations? If there are Key Populations specific books, there is not a high risk to expose for the people who discriminate and look for that communities to punish?

Response: We try to maintain a high degree of confidentiality for client records. So, we are using KP specific data tools. We provide for "others" in case a client does not want to identify their identity, but we have KP friendly clinics in hot spots which are known

How does DIC reduce stigma and discrimination since they segregating themselves? Why not talk about integration of services and train providers to have friendly services?

Response: It is important to have both options, as key population groups are not homogeneous. But KP-led DICs often have greater access to peers, psychosocial support, tailored services, and a supportive and private environment. There are several sessions/case studies on DICs throughout the meeting.

Response: DICs also provides access to KPs who are afraid to visit public health KP facilities. Plus, as mentioned, it provides friendly services that fit FSWs expectation and needs.

Ugandan team, thanks. Are the communities you serve aware that this project will end one day? Are they willing to pay for some of these services?

Response: Under the Public health approach, all primary health care services are free in Uganda paid for by government, so the issue is how to keep engaging govt to provide these services. More so the commodities are same for all population so we can easily provide the services under PHC

Can anyone share how self-testing is monitored - especially in the private sector - beyond # of kits distributed. Ex how do you know the # of those who tested themselves; how many tested positive, how many of the positives got retested at the HF, etc?

Response:

Is it sustainable to have those centers? Most of them are financed by partners

Response: Very challenging but one of the most important approaches is to use government facilities but also build capacity of communities

In Uganda; How are DICs established in selected public Hospitals?

Response: We have an SOP on establishing and operating DICs under MoH. They will be posted on the meeting website under the Resources page.

For Macklean Kyomya: Do you have many any Psychosocial support component in your support for the KPs especially the FSWs and do you have a trained Peers that do this?

Response:

Any insurance scheme in Uganda?

Response: None yet. But we are discussing this for the last 20 years... soon we will get a breakthrough